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Contributing to Health Systems Strengthening

Guiding principles for
National TB programmes and partners

1. Why a Health Systems Strengthening component in the Stop TB Strategy?

The inclusion of "Contribution to Health Systems Strengthening (HSS)" in the new Stop TB strategy explicitly acknowledges that effective and sustainable TB control relies on the general health system, especially on well-functioning Primary Health Care. Weak health systems pose many barriers to effective TB control. The HSS component aims to sensitize NTP managers to ongoing developments in the health sector and assist them in becoming active participants in the process. NTP and its TB control partners should be aware of the various HSS initiatives in the country. Where possible, NTP managers should engage proactively in these initiatives. Awareness and participation may be crucial in preserving priority and funding for TB control in a changing health system[1].

TB programmes are an important part of health systems, and TB programmes are contributing substantially to HSS through investments in laboratory infrastructure, training of health staff, as well as through developing innovative service delivery strategies such as PAL, PPM, and Community-based DOTS in response to specific health systems barriers[2]. NTPs may further contribute strengthening of the general health system by considering a set of guiding ***"dos and don'ts for HSS"***, which promotes:

- Harmonization of TB control planning and budgeting process with sector-wide planning frameworks;
- Optimization of the use of shared resources such as the frontline health staff; and
- Reduction of duplicative structures.

While striving for further harmonization and integration, NTP managers must however ensure that core TB control activities are not compromised. This requires preserving some ***"non-negotiable TB specific functions"***. The balance between integration and the retention of key 'vertical' elements will vary across countries, depending in particular on the robustness of the general health system.

2. What does contribution to HSS mean in practice for NTPs?

For NTPs, contribution to HSS involves:

1. Help analyse general health systems barriers.
2. Identify opportunities and threats of ongoing/planned health sector development processes.
3. Address barriers, threats and opportunities while applying "dos and don'ts" and "non-negotiables".

2.1. Help analyse health systems barriers

Potential health systems weaknesses which may negatively impact TB control are listed in Box 1, grouped under the six health systems "building blocks" defined in WHO's Health Systems Strengthening Strategy.[3] The relevant focus of analysis depends on country context, including structure of the general health system and the fit of the TB programme within the health systems.

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[1] Expanding DOTS in the context of a changing health system. WH//CDS/2003.318. Geneva: WHO, 2003

[2] How the Stop TB Strategy can contribute to Health Systems Strengthening. Geneva: WHO, Stop TB Department, 2006.

[3] Everybody's business - Strengthening health systems to improve health outcomes: WHO's framework for action. Draft 15 June 2007. Geneva: WHO, 2007.

Guidance on methodology for assessment of health systems barriers is not included in this document. Identification of health systems barriers is a part of routine programme planning[4] and reviews.[5] Routine TB programme monitoring and evaluation often reveal programme limitations that stem from weaknesses of the general health system. A common-sense approach based on routine programme monitoring and evaluation is sufficient for identification of main systems barriers in most situations.

TB programme are often in a unique position to contribute to the understanding of general health systems deficiencies through the relatively advanced monitoring and evaluation system for TB control used in many countries. By closely monitoring performance indicators, such as number of outpatient visits, number of TB suspects investigated, sputum positivity, case notification, and treatment outcomes, NTPs can help identify weaknesses in the general health system in which the TB programme is integrated. The monitoring of certain aspects of programme management, including health workforce, drug management, laboratory quality, role of private sector and community, etc can also generates data that can help healthy policy makers identify areas of the general health system that need to be improved.

The document "Expanding DOTS in the context of a changing health system"[1] provides further guidance on assessment of health systems barriers. In addition, a specific tools for assessing health systems barriers for TB control is available, which can be used for more advanced analyses by health systems specialists[6].

Box 1. Potential health systems weaknesses with implications for TB control

[4] WHO. Tuberculosis handbook. WHO/TB/98.253. Geneva: WHO, 1998 (to be updates with revised "handbook").
[5] Guidelines for conducting a review of a national tuberculosis programme. WHO/TB/98.240. Geneva: WHO, 1998.
[6] Atun R, Lennox-Chhugani N, Coker RJ. Systemic Rapid Assessment Toolkit - a toolkit for rapid assessment of health systems and tuberculosis control. London: Imperial College, 2006.

Leadership and governance

- Weak capacity for health policy analysis, priority setting, sector policy development and central health sector management. This may involve both quantitative and qualitative manpower limitations as well as limitations related to planning and decision making structures.
- Poor coordination between different public sector entities involved in health care planning and implementation, including limited coordination between different ministries and between national, provincial, city corporation and local governments. Decentralization with increased local autonomy without sufficient legalisation and central coordination securing adequate disease control measures.
- Limited "fiscal space" and caps on expansion of resources in the health sector.
- Weak health sector regulation and limited mechanisms and resources for enforcing existing regulation
- Non-existent or weak policy concerning the role of the private health care sector, including limited information on the private sector, poor regulatory framework and mechanisms.

Health financing

- Limited general health sector budgets.
- Unfair financing systems, e.g. absence or low coverage of health insurance with ability to pool and redistribute resources in a way which minimizes financial access barriers.
- Weak financial steering mechanisms for strategic resource allocation and purchasing of services.
- Weak mechanisms for tracking financial flows and poor capacity for performing national health accounts.

Health workforce

- Lack of basic information about the health work force density, distribution and skill mix.
- Insufficient size and competence of the health workforce.
- Weak structure and poor quality of educational systems for health professionals.
- Weak structure and quality for continued medical education.
- Poor supervision and quality control mechanisms.
- Perverse incentives linked to employment policies, salary structure and payment mechanisms.
- Weak regulation concerning private health care provision by staff employed in the public sector.

Medical products and technologies

- Weak regulation of medical products and/or weak enforcement mechanisms.
- Weak systems for procurement, distribution and management of drugs and equipment.

Health information system

- Poor quality of vital statistics and demographic information.
- Weak general systems for disease surveillance.
- Poor disease notification system.
- Lack of data on available human resources for health and available public and private health providers.
- Lack of data on health care utilization patterns.
- Limited skills to analyse existing data.
- Limited capacity for health systems research and operational research.

Health service delivery

- Lack of basic information concerning number, composition, and geographical distribution of all health providers (public and private), and the type and quality of the services they provide.
- Lack of comprehensive policy and plan for optimal utilization of existing health providers, including the private sector.
- Limited capacity to plan and manage health care provision, including contracting, certification and accreditation of public and private providers.
- Limited use of quality standards and evidence based guidelines.
- Poor systems for referrals and information exchange between providers.

2.2. Identify opportunities and threats of health sector development processes

The potential barriers listed in Box 1 are mostly beyond the direct influence of national TB programmes. They are determined by broader political and economic national and international policies and trends. TB programmes need to plan and implement realistic strategies within the limits set by such policies. However, TB programmes should also try to become more proactively involved in processes aimed to improve the general health system.

Health sector reforms can bring major opportunities for improved TB control, through improving health care financing, infrastructure, health work force capacity, etc. However, health sector reform are shaped through complex, and not always transparent, domestic as well as international political processes. TB programme managers are not normally at the centre of such processes, and may not even be fully informed about objectives and mechanisms of the health sector reform processes. This puts programmes at risk of being neglected and even damaged during health sector reforms. It may also lead to missed opportunities for TB programmes to proactively contribute lessons, experiences, and know-how that could contribute to general health systems strengthening.

It is therefore key that TB programme stay tuned with and proactively try to influence health sector reform processes. Example of reforms that may be implemented include: Decentralization and devolution of health care financing and decision making; Privatisation and/or provider/purchaser split with more independent health institutions; Changing financing mechanisms, e.g. introduction of health insurance schemes.

Similarly, it is important that TB programmes are aware of broader health care planning and financing frameworks, processes and concepts used by MoH, partners and international donors. This includes, for example, processes to align donor funding streams with a comprehensive health sector plan and budget, such Sector Wide Approaches (SWAPs), budgeting mechanism that aims to bring a multiyear perspective to the annual budgeting cycle, such as Medium Term Expenditure Frameworks (MTEF), and strategies for broad-based growth and poverty reduction, such as Poverty Reduction Strategy Paper (PRSP). A comprehensive document has already been developed to guide TB programmes how to respond to and plan TB services in light of health sector reforms.[1] Annex 1 provides a brief summary of what SWAPs, MTEFs and PRSPs are.

2.3. Address barriers, threats and opportunities while applying principles of "dos and don'ts" and "non-negotiables"

Having identified health systems barriers and mapped out ongoing and planned health sector development processes, NTPs should devise HSS actions which balance three objectives:

1. To help improve the capacity of the general health system to effectively deliver TB control services.
2. To optimize the positive impact on the general health system of specific TB programme activities, through adequate integration and harmonization of financing, planning and service delivery (The "dos and don'ts").
3. To protect essential TB specific function which may be damaged during health sector reforms and processes to promote integration and harmonization (The "non-negotiables").

The mandate of NTP is to improve the health systems' capacity to delivery quality TB control interventions. Especially when health systems are weak, this may require the creation of separate, or "vertical" structures for TB control. This may mean additional transaction costs for already

constrained health systems. While certain TB specific elements are required in order to ensure good quality and coverage, TB control should be planned and implemented with a goal to ensure alignment and harmonization ("dos and don'ts") with the general health systems in order to optimize use of limited resources for health.

This does not mean full integration of all aspects of a TB programme into general health services. All countries need to retain certain specific disease control functions, including specific TB control functions. What is means is that NTPs and partners need to strike a balance between the need for "non-negotiable" TB specific elements and the risk of creating unnecessary and costly parallel structures.

Indicative "does and don'ts" for HSS and "non-negotiables" for protecting TB control functions are listed below. These should be considered as guiding principles, not as strict rules. Country context, strength of the general health system, and TB burden will determine the appropriate balance.

The Dos and Don'ts for HSS

Leadership, governance and financing

Do

- Maximize alignment of TB programme planning into overall health sector planning frameworks
- Collaborate across public health programmes to promote joint planning and share programmatic policies and strategies.
- Improving coordination of external technical assistance for TB with other technical assistance.
- Align budgets and programme-specific financial flows within Medium-term Expenditure Frameworks or equivalent resource allocation tools.
- Pool all domestic and international NTP funding into a "mini-basket" fund for TB control.
- Pursue policies that reduce out-of-pocket spending on health care.
- When engaging the NGO and private sector, ensure that the stewardship function remain with Ministry of Health and that major financing and financial steering possibilities are not diverted to non-state sector providers.

Don't

- Develop national TB control strategy and implementation plans in isolation from overall health systems planning.
- Create parallel administration, reporting and monitoring systems for different sources of external funding.

Health workforce

Do

- Use a systematic approach based on job descriptions to: (a) clearly determine HR needs for comprehensive TB control; (b) develop long term strategic plans and (c) medium term implementation plans to enable greater alignment with general human resource development.
- Collaborate and coordinate with other specific disease programmes, with other departments and services in the MOH as well as other units and services in the provincial/district health services to ensure synergy and consistency with overall local health sector plans and capacity-building frameworks.

- Share experiences of how to engage the health workforce outside the public health sector, human through PPM and community involvement in TB control, with other disease programmes and other health system stakeholders.

Don't

- Develop programme specific solutions to speed up implementation of TB interventions without considering implications for other programmes, e.g. intervention-specific incentives, or increasing number of emergency or longer-term staff.
- Develop implementation plans for HRD without being realistic about the time needed and the opportunity cost related to time spent on training.

Medical products and technologies (Drugs and labs)

Do

- Plan actions to strengthening the capacity of laboratory services to perform sputum smear microscopy, culture, DST, and new diagnostic tools together with relevant planning units in MoH, other public health programmes, and across all public and private providers, in order to avoid duplication and additional transaction costs.
- Develop national procurement, distribution and stock management systems which are harmonized, and integrated (when relevant and possible) with general supply systems.
- If urgent temporary systems are required to ensure safe and timely delivery, ensure they are planned with central authorities and that support is provided to supplant them by integrated systems as quickly as possible.

Don't

- Develop or maintain parallel systems for drug management when strong general lab and drug management systems are in place or under development.

Health information system (M&E)

Do

- Ensure that the recording and reporting system is harmonized with national health information systems.
- Align monitoring requirements with overall poverty and health monitoring master plans in the country and work with donors to consolidate reporting demands.
- Share information from TB M&E (performance and programme management data) to help map health systems deficiencies and opportunities.
- Seek common platforms for any service- or population-based surveys.

Don't

- Create new indicators without careful consideration about overlap and inconsistence with general health systems performance indicators.
- Demand unnecessary process indicators or special reports on performance beyond routine reporting requirements.

Health service provision (including management and supervision)

Do

- Harmonize management and supervision structures with general health systems managerial structures, including mechanisms for working with the non-state sector.

- Plan delivery of diagnostic and treatment services with relevant authorities responsible for the planning of service delivery on all levels, but especially in primary health care.
- Join efforts to build competencies that are common to all health care managers.
- Harmonize quality standards with general health system quality standards.
- Implement PAL as a means to strengthen management of respiratory illnesses in PHC.
- Share experiences and expertise on how to engage all care providers and communities in TB control, and strive to coordinate such initiatives with initiatives of other public health programmes to work with these sectors.

Don't

- Plan and implement supervision and quality control in isolation from general health service supervision and quality control.
- Create incentives structures that distort priority-setting and/or performance in other areas of work among managers and supervisors.

The Non-negotiable TB specific functions and structures

1. Tuberculosis continues to be considered a ***priority disease***. Specifically:
   - It is explicitly listed as a 'priority' in sector strategy, planning and policy documents.
   - TB control is included in any essential or basic package of health services.
   - Anti-TB drugs are included in any essential drugs package.
   - TB control indicators figure prominently in the routine reports of a unified health management and information system.

2. There is a ***clear and well-specified operational plan*** for implementation and expansion of high quality DOTS. In the context of a unified health sector plan, the TB control component is transparent, and supported by clear commitments of financial, human and other resources.

3. There is ***TB management capacity*** with competencies in policy and planning, budgeting, logistics including drug procurement and distribution, monitoring and surveillance and laboratory supervision:
   - There is one or more dedicated senior staff with overall accountability for TB control within the country.
   - There are dedicated staff to ensure smooth flow of anti-TB drugs - job responsibilities include estimation of need, ensuring timely procurement, preparing distribution lists, and tracking stock and flow.
   - There are dedicated staff for managing the TB control information system - collating lower level case finding and treatment reports, and conducting national level quarterly cohort analysis.
   - Where possible, core management and technical staff in the national unit of the NTP are retained.
   - The national unit has sufficient operational budget (beyond salaries and other fixed overheads) to be able to carry out supervisory activity, essential training programmes, and carry out fire fighting exercises during a crisis e.g. drug stock out in a province etc. Thus, a TB control line item in the budget is preserved.
   - There is dedicated TB supervision capacity at the district level, in particular in high and intermediate burden countries with weak health systems. The TB coordinator is supported with adequate financial and physical resources (a vehicle, communication device etc).

3. How to assess contribution to HSS in a programme review?

This section lists key questions for the assessment of how NTP is performing with regards to contribution to HSS. It can be used as a checklist for external programme reviews or for internal review processes. The ambition level of such an assessment depends on the objectives of the review and resources available. Experiences from a number of regular external TB programme reviews have demonstrated that it is feasible to address most of the questions below during a one to two week mission.

The assessment should provide an overview of the extent to which TB control planning and financing is through "vertical" streams vs. integrated planning and budgeting processes. This would highlight to what extent different TB control functions are dependent on the capacity of the general health system. This, in turn would help identify specific health systems barriers as well as future threats and opportunities of changes to health sector budgeting and financing. It should help NTP identify planned/ongoing reform processes and advice on how NTP could become proactively involved in such processes, with a view both to improve and/or protect essential TB control functions, and to actively contribute to positive outcomes of reforms processes for the general health system.

The assessment should also identify shortcomings as well as opportunities with regards to improving joint planning across public health programmes to exploit potential synergisms, e.g. through optimizing joint utilization of common supply chains, supervision and quality control structures, and services delivery by general health staff.

The assessment may focus on the following seven broad questions:

1. To what extent is the TB programme integrated into the general health system (see Box 2)?
2. In light of the degree of integration, what specific health systems weaknesses constitute barriers for TB control?
3. What health sector development processes/reforms are planned/ongoing, and what positive or negative impact might they have on TB control?
4. To what extent is NTP involved in influencing these processes/reforms, and how can NTP become more proactive?
5. To what extent is NTP adhering to "dos and don'ts" while protecting the "non-negotiables"?
6. Are deviations form the "dos and don't" and "non-negotiables" appropriate considering the strength of the health system and the existing TB control challenges?
7. How can NTP further improve positive impact of programme implementation on general health system, through applying dos and don'ts principles, and through actively sharing experiences of service delivery innovations such as PAL, PPM and Community TB Care?

Indicative dos and don'ts and non-negotiables are listed in section 2.3. above. Specific questions for the assessment of degree of integration are listed in Box 2.

Box 2: Key questions to assess degree of TB control integration into the general health system

Financing and funding streams

- What are the main domestic and international funding sources for TB control and what are the shares of different funding source?
- Are there different reporting requirements for the different sources?
- What is the share of the NTP budget (domestic+ donor contribution) of total expenditure on TB control (including TB control costs incurred by the general health system)?
- What is the share of NTP budget out of total government expenditure on health?
- To what extent are funds for TB control allocated in line with the national health development plan, PRSP, MTEF, and SWAp?

Overall planning, HR strategy, and lines of authority for supervision and quality control

- Apart from NTP, which national partners have taken part in the planning of TB control? (e.g. MoH planning department; Hospital administration department or equivalent; Other ministries such as Ministry of Education, Ministry of Interior/Justice, Ministry of Defence, etc; Drug regulatory body; National health insurance office; HIV programme; Other public health programmes; NGOs; Professional associations, etc).
- Is the strategic plan for HRD for TB control linked to and coordinated with the national human resources for health plans for the entire health sector?
- On what levels of the health system are there staff who are full time dedicated to TB control, and who is paying their salary, NTP or general health system (provincial/state, district/sub-district, health facility level).
- What is the line of authority for personnel responsible for supervising TB control implementation on provincial/state and district/local levels: are they accountable directly to NTP or to managers of the general health system?

Supply chains, and delivery of diagnostic and treatment services

- Is TB drug procurement, distribution and stock management systems integrated with general drug management systems; fully, partly or not at all?
- Are lab supplies and stock management systems integrated with general drug management systems; fully, partly or not at all?
- Are labs for TB diagnosis integrated into general labs fully, partly or not at all?
- What health staff is responsible for identification of TB suspects, diagnosis, treatment, DOT, defaulter retrieval, staff of NTP / contractual workers or general health staff?

Annex 1

Sector-wide Approach (SWAp)

SWAp is a partnership mechanism to align donor funding streams with a comprehensive health sector plan and budget. The recipient government takes the lead in strategy formulation and plan implementation. The government evaluates the health needs of the country as a whole and establishes priorities. Often, funds from donors and the government are pooled in a 'basket' and then allocated to these priority activities. Donor focus tends to shift from technical and funding assistance to specialized health interventions to collaboration with the Ministry of Health in sectoral planning and performance monitoring. The potential benefits of SWAp include greater national ownership of health sector planning and budgeting, reduced duplication and conflict in donor activities, and presumably more rational evidence-based allocation of resources.

For NTPs, the major risk posed by SWAps is the loss of dedicated donor funding that may be crucial for key TB control inputs and operations. Whether enough funds are made available to the NTP from the 'basket' depends on the priority accorded to TB control in the health sector plan. However many countries have defined an essential package of health interventions and TB is almost always included in this package.

Medium Term Expenditure Framework (MTEF)

The MTEF is a budgeting mechanism that aims to bring a multiyear perspective to the annual budgeting cycle. Social programs e.g. health and education have long term needs and intelligent budgeting should have a longer term view of macro-economic realities and trends in expected government revenue and donor funding. MTEF is a rolling process with a medium term horizon (usually up to 3 years in the future.) There are three components: a top-down estimate of the total resources available for public expenditure based on overall macro-economic goals, a bottom-up estimate that is the sum of the expected line expenditures in different programs, and a framework for reconciling the two estimates. MTEF can be implemented on a sectoral basis too. The MTEF helps create a more predictable environment for planning activities since planners have an idea of the overall spending envelope and how it is likely to evolve. The focus shifts from short term cash management to medium term expenditure planning.

In countries that have adopted MTEF for health sector and/or overall budgeting, NTP managers may have to synchronize their budgeting and five year operational plans with the MTEF process.

Poverty Reduction Strategy Papers (PRSP)

A Poverty Reduction Strategy Paper (PRSP) spells out a comprehensive country strategy for broad based growth and poverty reduction. It is prepared by the government in consultation with domestic stakeholders and external development partners, in particular the IMF and the World Bank. A PRSP will typically detail the macroeconomic and structural polices, and social programs planned over several years, and the associated external financing needs. PRSPs provide the operational basis for concessional lending and debt relief by the IMF and the World Bank. PRSPs are updated every three years with annual progress reports. A PRSP will contain a discussion of the health sector and the

current health status of the population with references to the MDG targets on key health indicators. In most countries, communicable disease control is mentioned separately and targets may be explicit.

The PRSP is a macro-level document of most relevance to very senior policy makers and donors. However, NTP managers may find it worthwhile to be familiar with the health sector discussion in the PRSP. It is indicative of government and donor priorities in the health sector over the medium term.